MODULES FOR TRAINING URBAN COMMUNITY HEALTH VOLUNTEERS

Unit 1

Urban Communities and Primary Health Care

VOLUNTARY HEALTH ASSOCIATION OF INDIA

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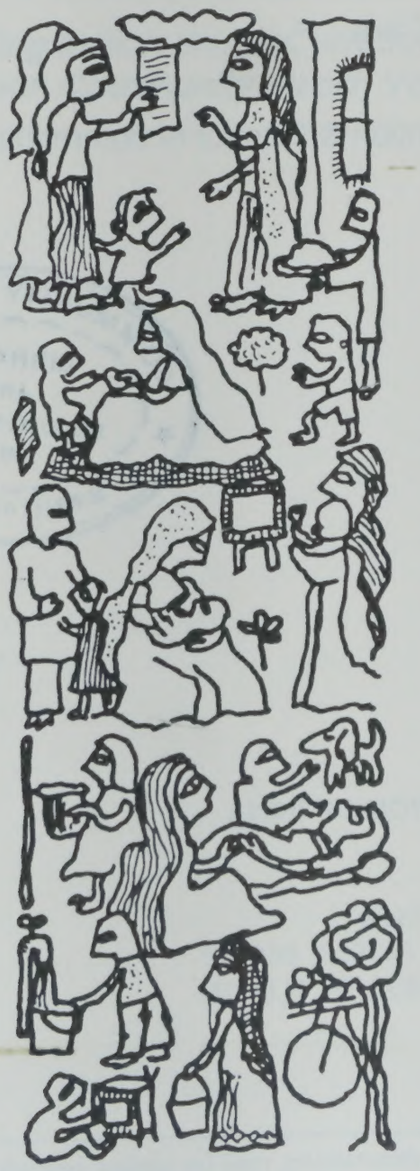
MODULES
FOR
TRAINING
URBAN COMMUNITY HEALTH VOLUNTEERS

UNIT 1
URBAN COMMUNITIES & PRIMARY HEALTH CARE



VOLUNTARY HEALTH ASSOCIATION OF INDIA

MODULES FOR TRAINING URBAN COMMUNITY HEALTH VOLUNTEERS

A set of 4 modules:

Unit **1** Urban Communities & Primary Health Care

Unit **2** Women & Health

Unit **3** Child Care

Unit **4** Prevention & Control of communicable diseases

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A: Understanding Indian Urban Communities

The development of primary health care programmes in urban communities is a complex task and needs to be accompanied by an understanding of the dynamic nature of urban populations. These include different factors that influence the nature and characteristics of urban slum dwellers, constant changes in populations and their resistance to community organisation.

This unit has been developed primarily for trainers of urban community health volunteers in order to:

a. increase their awareness about the *impact of urbanisation on poor slum communities* and

b. gain an overview of the *challenges and constraints of working in an urban slum community.*

1. URBANISATION & IT'S IMPACT ON HEALTH:

Our total urban population has been estimated to be 217.18 million which amounts to 25.72% of our total population.The urban population has almost doubled during the last two decades from 109.11 million in 1971 to 217.18 million in 1991. A similar doubling of the urban population was also observed during the period 1961-81 (1991 Census data. See Figures 1-2.) Among the poor urban populations such a rapid overall increase often goes unrecognised and is by and large accompanied by poor provision of essential infrastructure and health care facilities.The absolute increase in the urban population during 1981-91 was reported as 58 million according to the 1991 census. A state wise breakdown of this decadal population can be referred to in Figure3. The size and rate of this increase is alarming and causes the demand for facilities and services to grow faster than resources available. More concerted efforts are required to review, understand and resolve problems encountered by the more vulnerable sections i.e. women and children.

Such rapid increasing levels of urbanisation in different parts of the country result in a combination of problems of under development and the more chronic health and social problems resulting from rapid industrialisation. The closely linked factors affecting the health status of urban populations, their work productivity and well being are complex and need to be understood in this context.

Among the urban population, a large proportion reside in urban slums with serious health problems. Figure 4 provides the estimated slum population in the 4 major indian cities.

Health and related problems of the urban poor can be categorised as:

- Direct problems of poverty eg unemployment, low income, exploitation, poor education;

- Manmade problems in the urban environment including effects of industrialisation;
- Cultural alienation, instability and insecurities as a result of psycho social problems.

Urban Primary Health Care programmes can include both health and health related activities: preventive and curative health care, improved water supply and sanitation, income generation activities etc.

Fig. 1
Growth of Urban Population

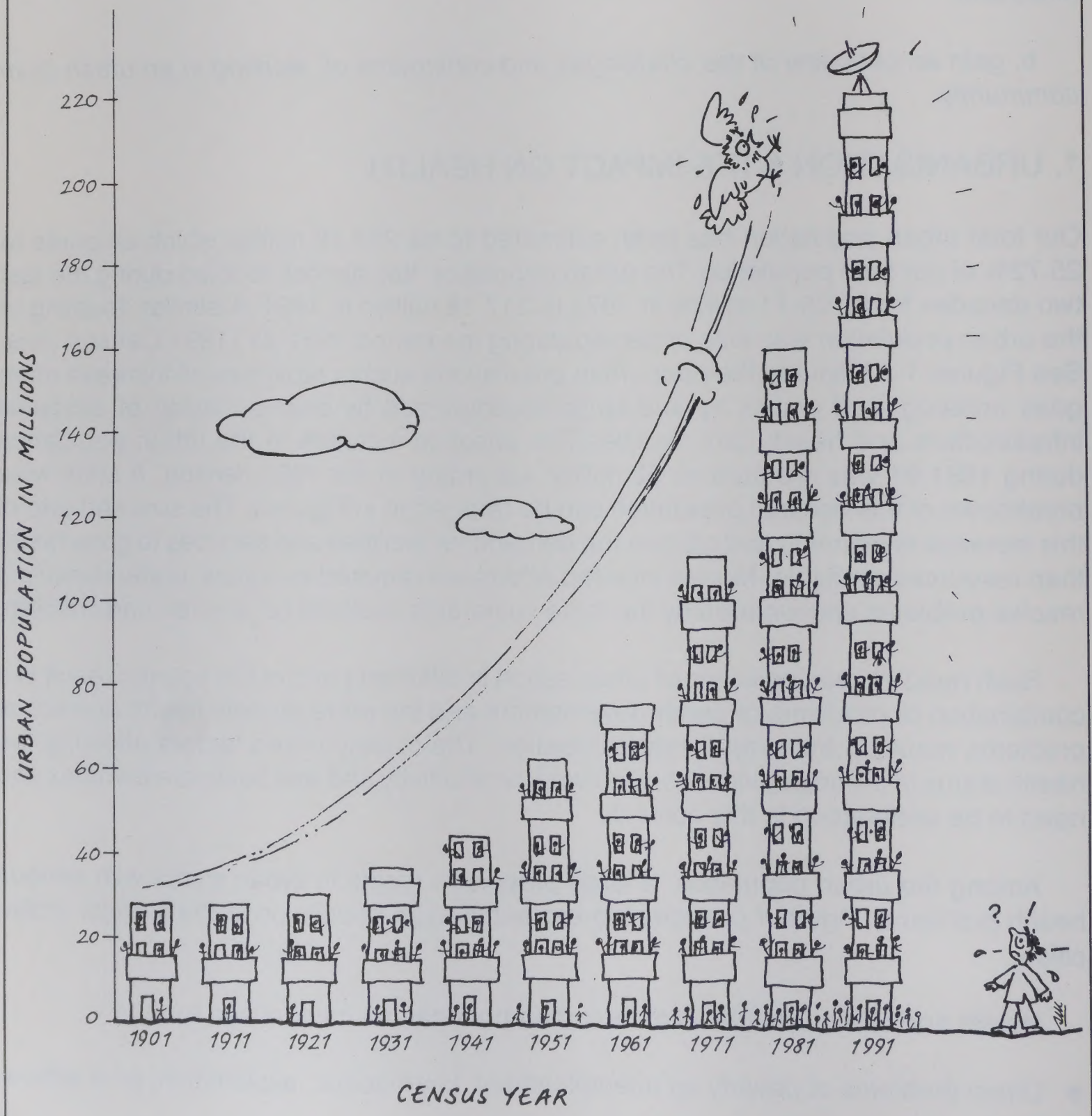


Fig 2
Decadel growth of Urban Population
1981-91

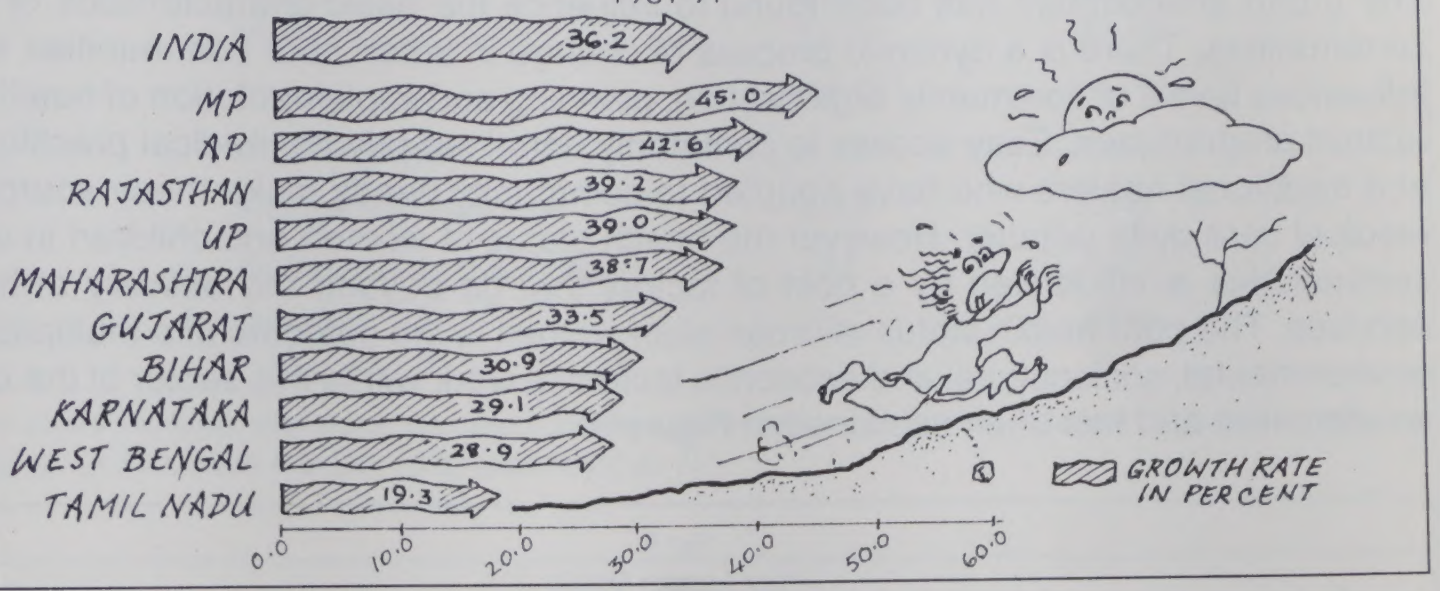


Fig 3
Urban Population of India and
Major States, 1991

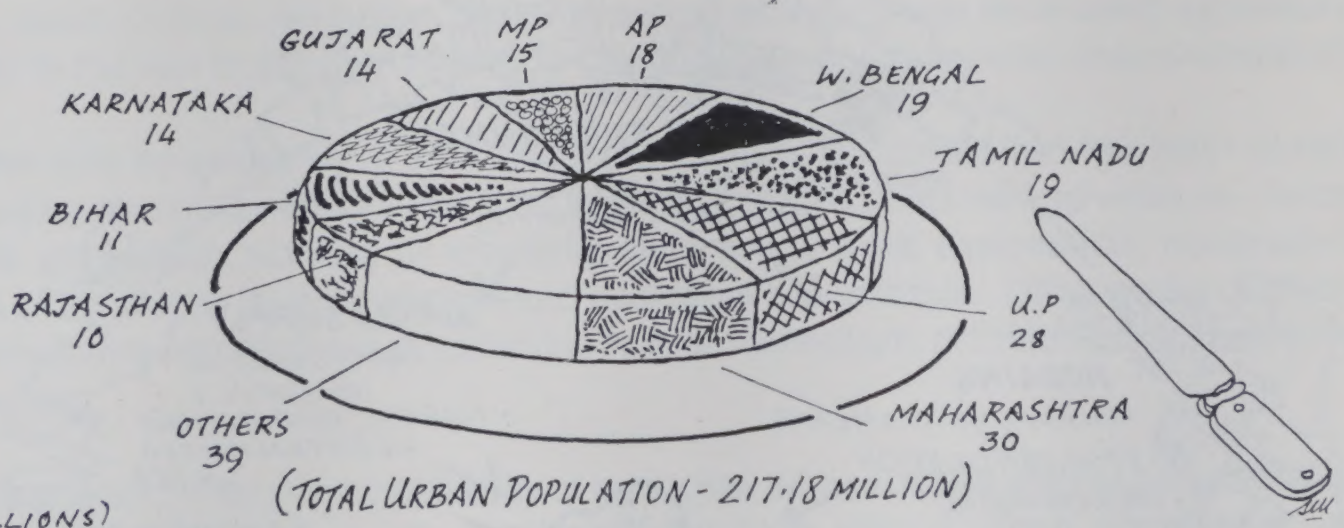
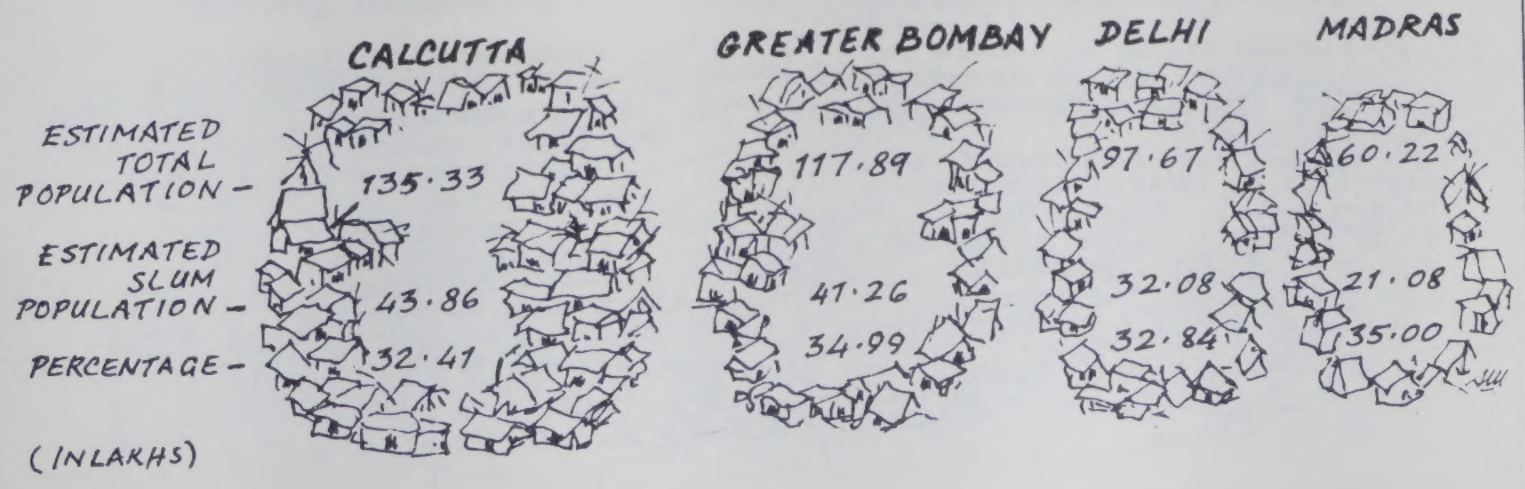


Fig 4
Estimated slum population
in some major cities



2. THE URBAN ENVIRONMENT:
Challenges and Constraints

The urban environment has been found to influence the basic characteristics of slum communities. There is a dynamic process of change in urban poor communities which influences levels of community organisation, planning and implementation of health and related programmes. Easy access to commonly untrained private medical practitioners and traditional healers who have adapted to community needs make these sources of medical care quite popular. However the health status of women and children in urban communities is influenced by a host of factors that go beyond the delivery of health services. The poor health status of urban slum women is the outcome of a multiplicity of environmental, sociocultural and economic factors at work within this sector of the urban environment and has been explained in Figure 5.

Fig 5
Poor Health Status
of Slum women

In the total urban slum population residing in selected project areas at Kanpur and Mirzapur, the base line data revealed the following :

	Kanpur	Mirzapur
Male	53.7%	53.9%
Female	46.3%	46.1%
Children (0-1yr)	4.3%	3.5%
Average household size	5.3%	6.6%
Eligible couples/1000 popln	167	218
Birth Rate	43	32.4%

The infant mortality rate in the selected slum population at Kanpur was found to be 114. with a birth rate as 43 and death rate per 1000 population as 12.

Compared with rural areas, urban populations are very heterogenous.This has often proved to be a major obstacle in community development. With higher levels of individualism and opportunism, collective responsibility remains low. Heterogenity extends to religion, caste, culture, language, customs and traditions. These have been exploited as observed in the rise in communalism and it's consequences in several urban populations.

Due to the very heterogenity of urban slum populations, Communalism has been used as a destructive and divisive force resulting in several victims of abuse and violence. Among the male population working in industrial slum areas work exploitation, occupational hazards of an industrial environment and accidents are common. Other social problems commonly found among these populations include alcoholism, prostitution, drug addiction and smoking.

In the urban sector there is a multiplicity of agencies, infrastructure and resources that are left unutilised and need to be developed. Working among urban populations one encounters several challenges and constraints that need to be understood for appropriate selection and training of community health volunteers.

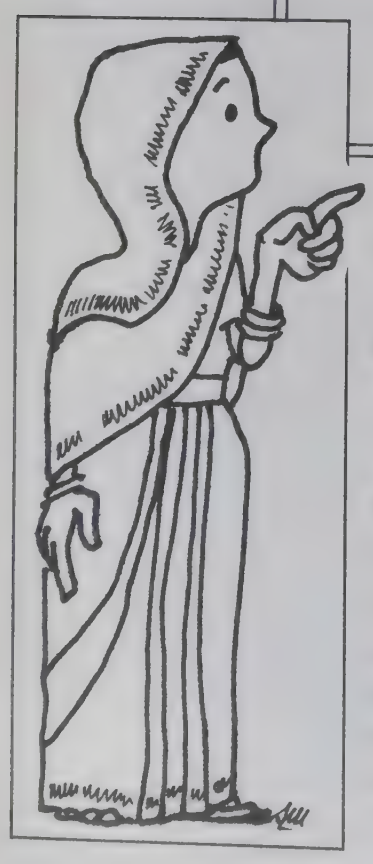
1. **Positive characteristics** that have been commonly recognised include their:

- Ability for hard work
- Inherent tenacity and resourcefulness
- Undaunted struggle for survival
- Alertness to available opportunities
- Capacity to adapt to changing situations and tolerance

2. **Several constraints** faced during working with urban populations include:

- Poor living conditions (overcrowding, limited space,inadequate house ventilation)
- Inadequate water and sanitation facilities
- Illegal housing
- Large unorganised work sector, low income & exploitation unemployment
- Resistance to community organisation programmes arising out of an individualistic and opportunist culture
- Erosion of traditional and cultural ethos
- Powerful social structures that resist change
- Mistrust of outside agencies and government programmes

AN INDEPTH UNDERSTANDING OF BOTH POSITIVE CHARACTERISTICS AND SEVERAL CONSTRAINTS FACED IS ESSENTIAL TO BUILD ANY FORM OF RAPPORT WITH COMMUNITY VOLUNTEERS AND URBAN POPULATIONS.



USEFUL REFERENCE MATERIAL:

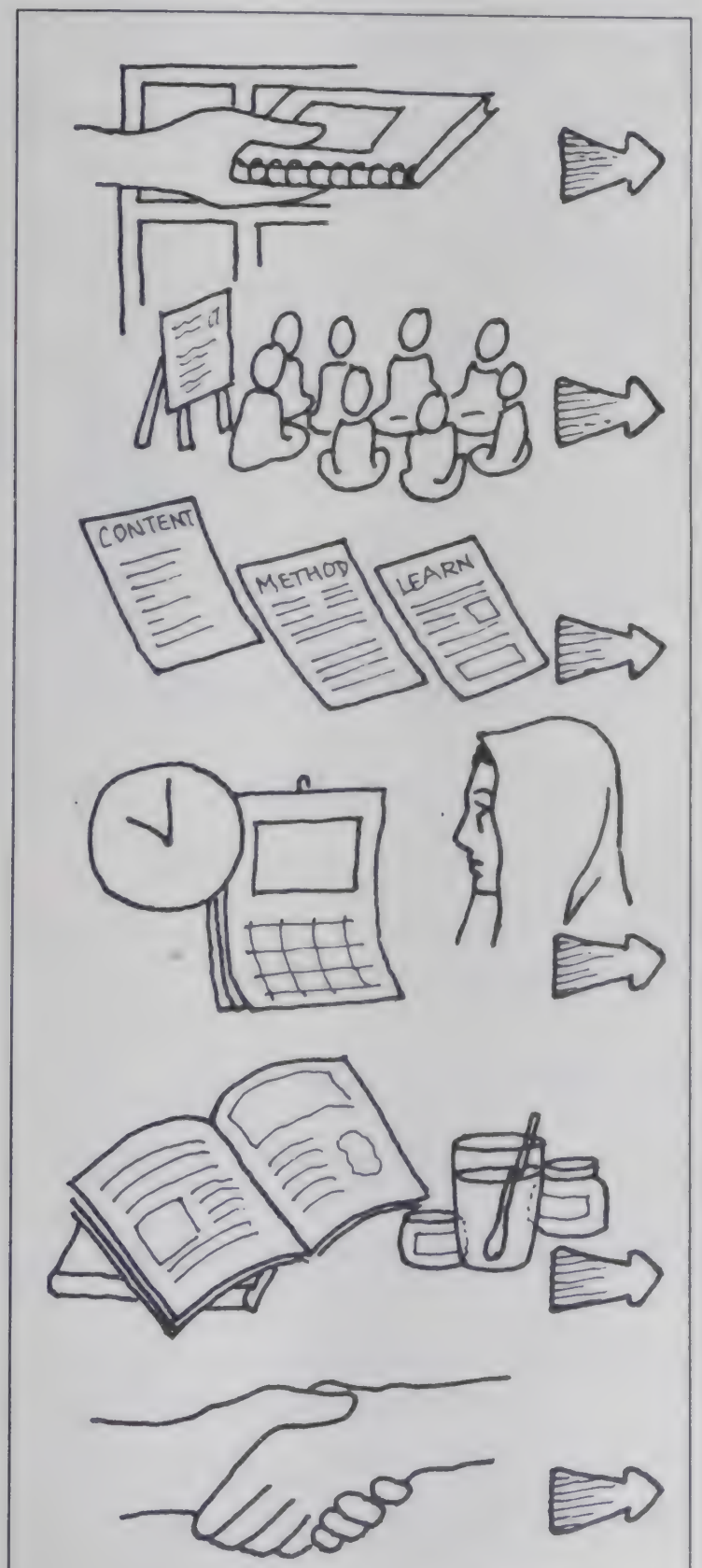
1.Ramasubban R, Singh B, Crook N 1991. War on Disease Bombay's Survival Kit. Colloquim India.

A useful book with ten stories that provide factual information about health problems and related conditions in the slums of Bombay with relevant arguments and potential catalysts for organised action to combat these. Stories are based on a dialogue between community members depicting real life situations commonly encountered by them and are also applicable to other slum communities. At the end, there is a useful essay on the pattern and magnitude of disease in the city and linkages relating to the knowledge, attitudes and practices that facilitate or obstruct the task of fighting disease within the overall urban environment, social and political situation.
Available from: Colloquim India, 402, Zeba Corner, Sherly Rajan Village, Carter Road, Bandra (W), Bombay 400 050

B: Training Urban Community Health Volunteers

The role of the community health volunteers (CHVs) is envisaged as a link between the community and project staff, available resources, services or schemes. Community health volunteers must be essentially from the community they serve and their success to a large extent depends on selection processes, community support, training and ongoing support and supervision.

For the trainer, the *process* of training of urban community health volunteers becomes an important one. An appropriate training strategy is one where:



Training inputs are urban based with acceptable training sites within easy access of CHVs

Training content is mainly determined by the expressed needs and problems encountered by communities

Contents, methodology and learning activities are suitably selected as in Units 2-4

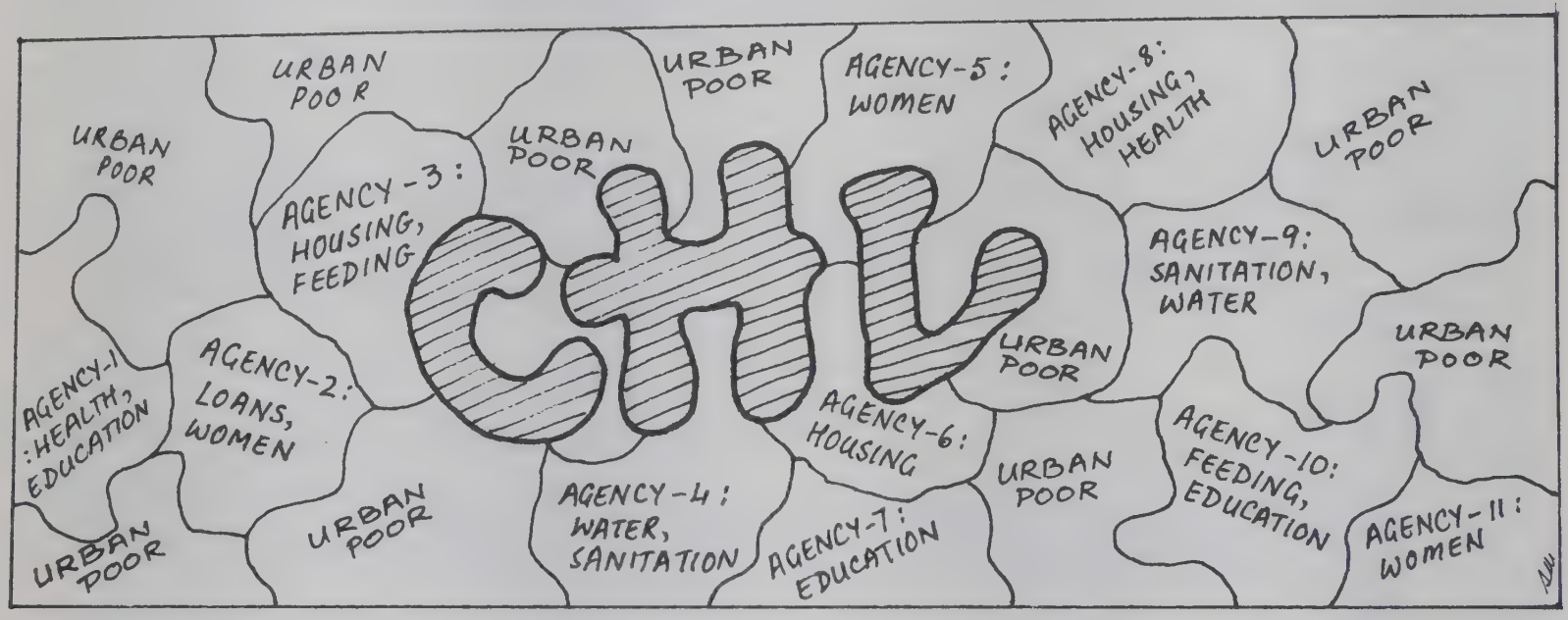
Time, duration, pace and structure of training should be convenient and learner oriented

Constant reinforcement of knowledge and skills during inservice training is given to increase motivation and performance levels of CHVs

Local resource personnel are utilised, thus strengthening intersectoral linkages and referral services

In most urban populations there is a strong curative culture. Medical care and curative services rather than preventive or promotional roles of community health volunteers have been found to be considered a priority by urban populations. Hence in order to prove beneficial to communities they serve, these roles need to be carefully integrated during training.

There is a multiplicity of agencies (government and nongovernment) working among the urban poor populations. Coordination with these agencies is a challenging task. In order to strengthen the position of CHVs it is important to constantly clarify and reinforce their roles and responsibilities in the community.



COMMUNITY HEALTH VOLUNTEERS: THEIR ROLE

Some important factors that can determine training priorities, tasks, roles and functions of community health volunteers include:

1. Existing morbidity and health service utilisation patterns in the project area
2. Emphasis on the development of an integrated programme stressing prevention, promotion and strengthening of the quality of existing curative services
3. Intersectoral Coordination:
   Establishing leadership and supportive roles within the existing cadre of health personnel
4. Ongoing supervision, guidance and support
5. Payment (in cash or kind) or provision of community incentives to CHVs for services rendered

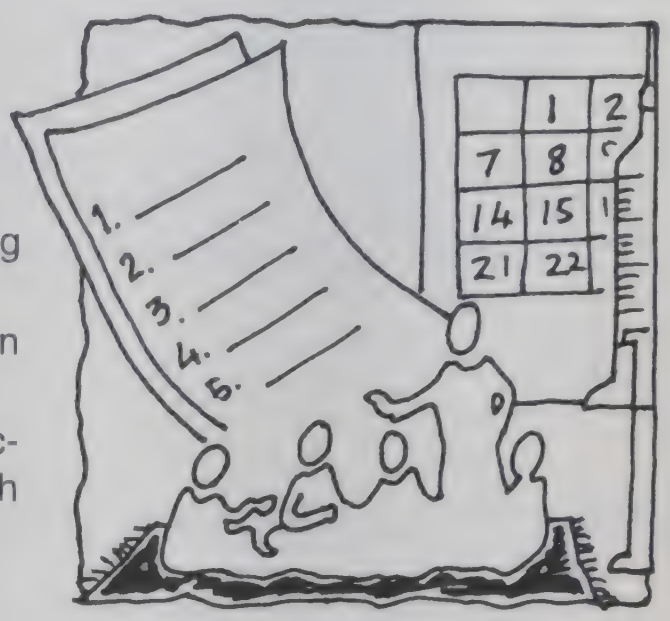
The possible roles of CHVs have been categorised and listed below. During the training process it is important to facilitate the gradual integration of various roles so that communities can find services rendered by CHVs beneficial.

A. Promotional:

(i) Immunization activities: eg.

- Promotion of immunization schedule
- Preparation of target lists (below 1 Year olds)
- Area based community meetings regarding preventable target diseases
- Community motivation based on immunization surveys

(ii) Health Education for promotion of: healthy practices based on existing disease patterns, health beliefs, customs and traditions.



B. Preventive:

(i) Care of Under five year old children:

- Assessment of their nutritional status
- Nutrition Education

(ii) Antenatal and Post natal Care

(iii) Assistance with Immunization services

(iv) Encouragement of use of child spacing methods

C. Curative :

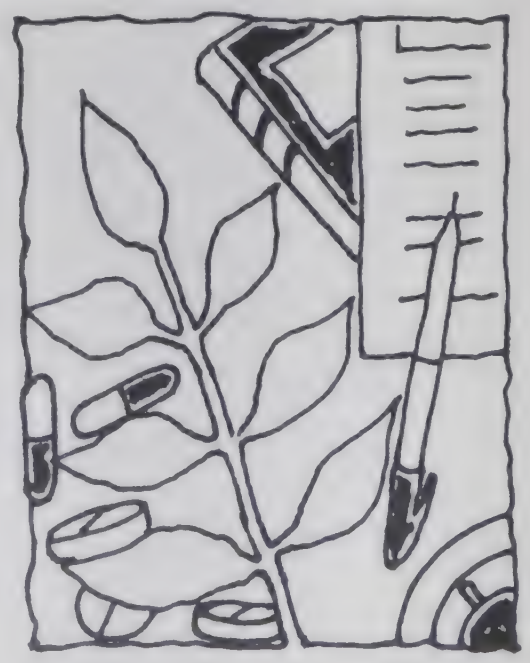
(i) Early detection of disease: Clinical assessment

(ii) Timely referral and followup:

- Identification of referral points in area: Private Medical Practitioners (PMPs), Hospitals and Health Centres
- Use of referral slips
- Record Keeping

(iii) Treatment of common ailments,

- Use of essential drugs and existing traditional practices



D. Community Organisation:

(i) Mapping Community Area and resources.

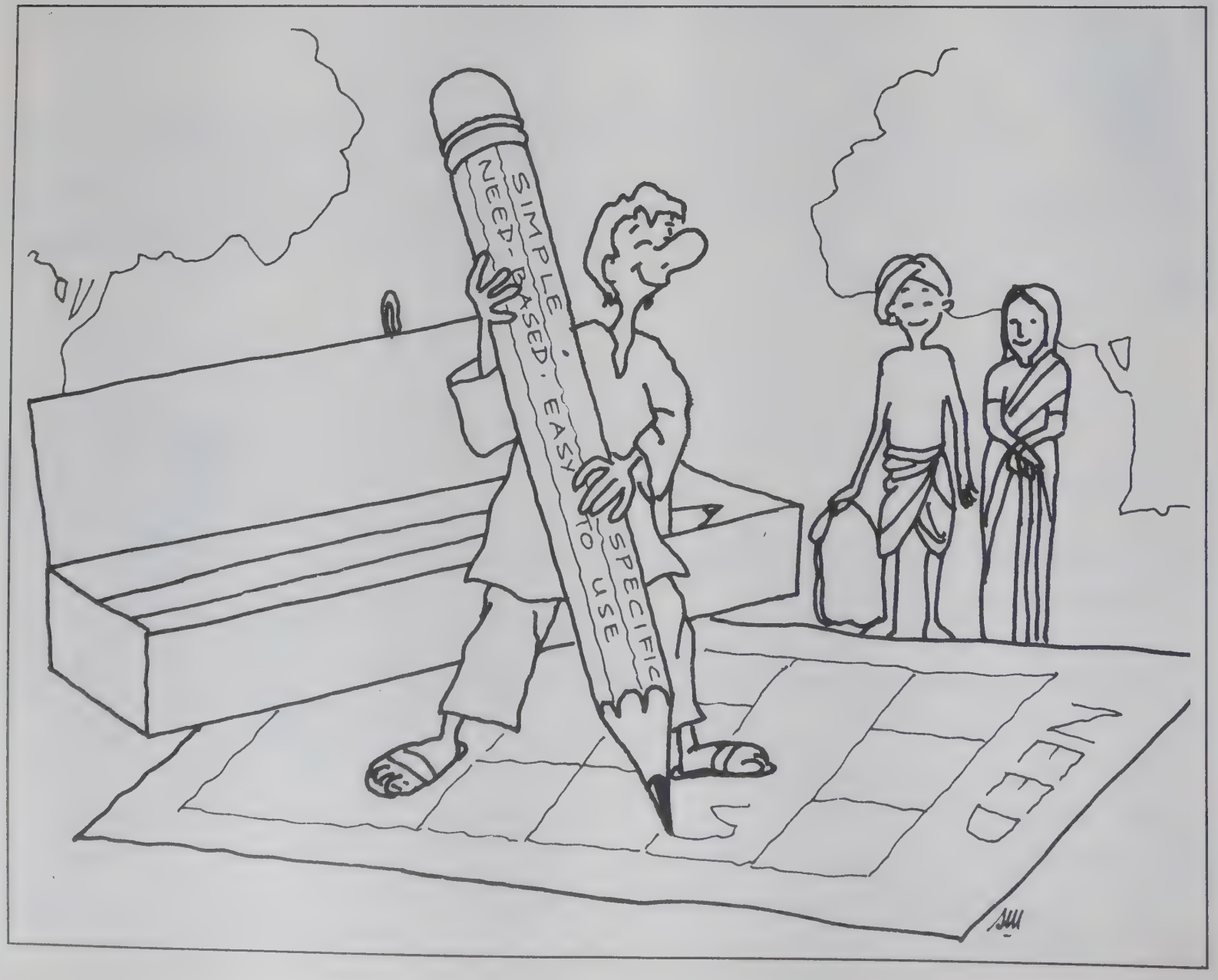
(ii) Identification of local leadership and organisations.

(iii) Organisation of areawise community and mandal meetings.

(iv) Liaison with other change agents and officials working at community level to assist community members to benefit from available services and schemes.

E. Monitoring & Evaluation:

It has been found that the involvement of community health volunteers in the monitoring and evaluation of primary health programmes increases community participation. Tools used for monitoring and evaluation should be simple, specific, needbased and easy to use.



Useful Reference Material

1. ASTHA 1986 *Adhi Adhuri Jhooti Sachai*

   (Hindi)

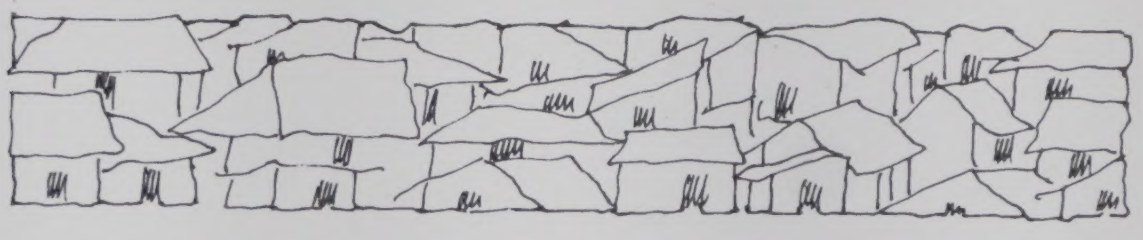
   A video film dealing with stereo types in three communities Hindu, Muslim and Christian Using puppetry in three short skits the film show how each of the groups is a victim of its own prejudices towards other groups. A study guide acompanies the film and contains a series of group exercises.

   Available from ASTHA, Xavier Insitute of Communications, Mahapalika Marg, Bombay 400 016.

2. VHAI 1992 *Hamari Chitthi Aap ke Naam* Vol. 1.5 No. 4 This periodical deals with communalism and expresions against it.

3. VHAI 1992. *Posters on communal Harmony* (Hindi).

   A set of six posters which can be used for understanding and explaining the different aspects of communal harmony.



TRAINER'S NOTE:

Regional ongoing support and supervision have been found to be vital in the monitoring and training of urban CHVs.

In order to enable community health volunteers to integrate selected tasks into their existing lifestyles, these should be carefully selected and built into the training activities gradually. Their roles and functions need to be based on their capacity and potential at an acceptable pace. The tasks to be performed can be reviewed periodically both by CHVs themselves and the project team depending on problems encountered, available resources, past performance and capacity of CHVs.

Voluntary Health Association of India (VHAI) is a non-profit registered society formed by the federation of Voluntary Health Associations organised at the level of States and Union Territories. VHAI links over 3000 grassroots-level organisations and community health programmes spread across the country.

VHAI's primary objectives are to promote community health, social justice and human rights related to the provision and distribution of health services in India.

VHAI fulfils these objectives through campaigning, policy research, and press and parliament advocacy; through need-based training and provision of information and documentation services; and through production and distribution of innovative health education materials and packages, in the form of print and audiovisuals, for a wide spectrum of users — both urban and rural.

VHAI tries to ensure that a people-oriented health policy is formulated and effectively implemented. It also endeavours to sensitise the larger public towards a scientific attitude to health, without ignoring India's natural traditions and resources.

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